

Case Number:	CM14-0129563		
Date Assigned:	08/20/2014	Date of Injury:	07/01/2008
Decision Date:	10/01/2014	UR Denial Date:	08/12/2014
Priority:	Standard	Application Received:	08/14/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 47 year old female who sustained an injury on 07/01/08. No specific mechanism of injury was noted. The injured worker has been followed for moderate to severe complaints of low back pain as well as mid back pain. The injured worker is noted to have had a prior lumbar fusion procedure completed. The injured worker has been previously treated with chiropractic manipulation, physical therapy, and injections. Medication history included the use of narcotic analgesics as well as anti-inflammatories. As of 08/01/14, the injured worker had continuing constant low back and mid back pain rating 8/10 in intensity. Medications at this evaluation included Norco, Soma, and Prilosec. The injured worker indicated that she had a recent exacerbation of her low back pain radiating to the lower extremities when getting up from seated position. Physical exam noted there were well-healed incisions in the lumbar spine region. There was diffused abdominal and epigastria tenderness. There was also tenderness in the sciatic notch bilaterally. Straight leg raise signs were positive. The injured worker was recommended to continue with physical therapy. Prior urine drug screen results were noted to be inconsistent for prescribed medications as there were negative findings for analgesics as well as Soma. The requested Soma 350mg and topical Flurbiprofen, Ketoprofen, Ketamine, Gabapentin, Cyclobenzaprine, and Capsaicin were all denied by utilization review on 08/12/14.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Soma 350mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-67.

Decision rationale: In regards to the use of Soma 350mg, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The chronic use of muscle relaxers is not recommended by current evidence based guidelines. At most, muscle relaxers are recommended for short term use only. The efficacy of chronic muscle relaxer use is not established in the clinical literature. There is no indication from the clinical reports that there had been any recent exacerbation of chronic pain or any evidence of a recent acute injury. Furthermore, the request is not specific in regards to frequency, quantity, or duration. Therefore, this reviewer would not have recommended ongoing use of this medication.

Flurbiprofen 20% Cream, 120gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Page(s): 111-113.

Decision rationale: In regards to the use of a compounded medication that includes Flurbiprofen 120gm, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The CA MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Flurbiprofen which is not approved for transdermal use. The clinical documentation provided did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound cannot be supported as medically necessary.

Ketoprofen 20%/Ketamine 10% Cream 120gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Page(s): 111-113.

Decision rationale: In regards to the use of a compounded medication that includes Ketoprofen and Ketamine 120gm, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based

guideline recommendations. The CA MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Ketoprofen and Ketamine which are not approved for transdermal use. The clinical documentation provided did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound cannot be supported as medically necessary.

Gabapentin 10%/Cyclobenzaprine 10%/Capsaicin 0.0375% Cream 120gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: In regards to the use of a compounded medication that includes Gabapentin, Cyclobenzaprine, and Capsaicin 120gm, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The CA MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Gabapentin and Cyclobenzaprine which is not approved for transdermal use. The clinical documentation provided did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound cannot be supported as medically necessary.